Atlas Family Health Center, LLC Financial Policy

Health Insurance: There is no direct relationship between Atlas Family Health Center, LLC and your insurance company. The type of plan chosen by you and/or your employer determines your benefits. It is your responsibility to understand your insurance policy. We are not responsible for the accuracy on any estimation of your coverage. Any insurance benefit explanations given by your health insurance provider is not a guarantee of payment. Please remember, regardless of insurance of any kind, ultimately you are responsible for your bill. A copay is required at the time of each visit.

Personal Injury Patients: Please provide to Atlas Family Health Center, LLC the auto insurance and or attorney name that will be billed. Contact information, responsible party and claim number will be needed to process claims. Any balance on your account when you are released from care will be charged to your credit card.

Payments: **PAYMENT IS REQUIRED AT THE TIME OF EACH VISIT**. While we accept cash and personal checks, Atlas Family Health Center, LLC requires that all patients keep a credit card on file. If we bill your insurance, the remaining balance after your insurance company processes the claim will be charged to your credit card.

Informed consent: A patient, in coming to Atlas Family Health Center, LLC, gives the Doctor, permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. I understand that if I am accepted as a patient by Atlas Family Health Center, LLC, I am authorizing them to proceed with any treatment that may be necessary.

HIPPA Notice: I understand and agree to allow Atlas Family Health Center, LLC to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. If you would like a more detailed count of the policy and procedures concerning privacy of your Patient Health Information we encourage you to read the HIPPA notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office. Additionally, I will allow Atlas Family Health Center, LLC to speak on my patient status when referred to by name by a referral source or another patient of this office.

I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. I authorize the release of medical information necessary to process my claims.

Credit Card #_____ Expiration Date: _____ CVS_____

Print Name: _____

Signature/Guardian: _____

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